

# CRIME VICTIM COMPENSATION

## HOMICIDE VICTIM'S SURVIVOR APPLICATION

(Please PRINT CLEARLY and fill out both sides)

Survivor's Name: _____			Office Use Only	
FIRST NAME	LAST NAME	SUFFIX	Claim Number _____	
ADDRESS: _____			Compensation Specialist	
CITY: _____		STATE: _____	ZIP: _____	
PHONE: (_____) _____		ALTERNATE PHONE: (_____) _____		
NAME OF HOMICIDE VICTIM: _____			THIS SURVIVOR'S RELATIONSHIP TO THE VICTIM: _____	

**IF THE ABOVE SURVIVOR IS A MINOR CHILD, ENTER INFORMATION HERE ABOUT THE PERSON COMPLETEING THIS FORM:**

NAME: _____	DATE OF BIRTH: _____	SOCIAL SECURITY #: _____
RELATIONSHIP TO CHILD: _____		PRIMARY LANGUAGE: _____

### COMPLETE THE FOLLOWING AND SIGN THE RELEASES ON THE BACK OF THE APPLICATION

#### 1. CRIME-RELATED EXPENSES: CHECK THE TYPE(S) OF CRIME-RELATED EXPENSES FOR WHICH YOU ARE SEEKING COMPENSATION:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> MEDICAL EXPENSES    | <input type="checkbox"/> LOST WAGES: (check all that apply) | <input type="checkbox"/> TRANSPORTATION: (check all that apply) |
| <input type="checkbox"/> COUNSELING EXPENSES | <input type="checkbox"/> FUNERAL, BURIAL, MEMORIAL SERVICE  | <input type="checkbox"/> FUNERAL, BURIAL, MEMORIAL SERVICE      |
| <input type="checkbox"/> LODGING             | <input type="checkbox"/> GRIEF LEAVE FROM WORK              | <input type="checkbox"/> GRIEF LEAVE FROM WORK                  |
|  | <input type="checkbox"/> MEDICAL / COUNSELING APPOINTMENTS  | <input type="checkbox"/> MEDICAL / COUNSELING APPOINTMENTS      |
|  | <input type="checkbox"/> COURT ATTENDANCE                   | <input type="checkbox"/> COURT ATTENDANCE                       |

#### 2. LOST WAGES: DATES MISSED DUE TO CRIME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMPLOYER'S PHONE: (\_\_\_\_\_) \_\_\_\_\_ CONTACT PERSON'S NAME: \_\_\_\_\_

#### 3. INSURANCE: CHECK ALL INSURANCES AVAILABLE TO THE SURVIVOR. (PROVIDE THE POLICY #, INSURANCE COMPANY NAME, AND ADDRESS)

- HEALTH INSURANCE: \_\_\_\_\_
- MEDICAID OR MEDICARE: \_\_\_\_\_
- NO INSURANCE COVERAGE.

#### 4. ATTORNEY: IS THE SURVIVOR REPRESENTED BY A PRIVATE ATTORNEY IN A CIVIL LAWSUIT OR INSURANCE ACTION RELATED TO THIS CRIME?

YES     NO     NOT AT THIS TIME

ATTORNEY'S NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_

#### 5. STATISTICAL INFORMATION: THIS INFORMATION IS REQUIRED BY FEDERAL REGULATION AND USED ONLY FOR STATISTICAL PURPOSES

A.) **GENDER:**  MALE  FEMALE    B.) **AGE:**  17 OR UNDER  18-63  64 & OVER    C.) **DISABLED:**  YES  NO

D.) **ETHNICITY:**  CAUCASIAN  NATIVE AMERICAN  AFRICAN AMERICAN  HISPANIC  ASIAN OR PACIFIC ISLANDER

OTHER \_\_\_\_\_

E.) **REFERRED BY:**  POLICE /SHERIFF  COUNTY ATTORNEY  MEDIA  HOSPITAL  VICTIM SERVICES  OTHER \_\_\_\_\_

F.) **SECONDARY VICTIM'S PRIMARY LANGUAGE:** \_\_\_\_\_

## **RELEASE OF INFORMATION AND REPAYMENT AGREEMENTS**

**SECTION 1 MUST BE SIGNED TO COMPLETE** YOUR APPLICATION FOR CRIME VICTIM COMPENSATION (CVC)  
**SECTIONS 2 AND 3 MUST BE COMPLETED AND SIGNED** TO RECEIVE MEDICAL AND COUNSELING BENEFITS  
(Use more paper for provider lists if necessary)

### **SECTION 1: REPAYMENT AND SUBROGATION AGREEMENT**

I understand that Iowa law requires me to repay the Crime Victim Compensation Program (CVC) if I receive any payment from the offender, a civil lawsuit, an insurance program, or another government or private agency after I receive payment from CVC for the same expenses. I also agree to notify the CVC if I have an attorney represent me in any action related to this crime. I certify the information in this application is true and correct to the best of my knowledge. I understand that with my signature I agree to all statements in this agreement.

**X SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
*Applicant signature (Parent or guardian must sign if victim is a minor or dependent adult; applicant must signed if victim is deceased.)*

### **SECTION 2: HEALTH CARE INFORMATION RELEASE**

**If known, list all providers such as doctor, clinic, hospital, dentist, ambulance, etc.**

<b>Provider</b>	<b>Address, City, State, Zip</b>	<b>Telephone</b>

I give permission to any hospital, clinic, doctor, insurance company, employer, person, or agency, including the University of Iowa Hospitals and Clinics, to give requested information, including medical records and test results which may include drug and alcohol and HIV & AIDS screening and related information to the CVC Program of the Iowa Department of Justice. This release does not authorize records protected under 42 CFR, Iowa Code Chapter 228 or Iowa Code section 141A.9. This authorization is valid for information already in existence and information generated while the authorization is in effect. I understand that:

- The CVC Program will request only information needed to determine benefits for which I am eligible.
- Iowa and federal law requires the CVC Program to keep confidential all confidential information received;
- This information release is valid for one year from the date of my signature and I can cancel the release by writing to the CVC Program at any time, except that if any information has already been received and used, it is not subject to cancellation.
- A photocopy of this signed form is as valid as the original; and
- My signature gives permission for the release of all information specified in this permission form.

**X SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
*Applicant signature (Parent or guardian must sign if victim is a minor or dependent adult; applicant must signed if victim is deceased.)*

### **SECTION 3: MENTAL HEALTH SPECIAL MEDICAL INFORMATION RELEASE**

The CVC will keep confidential all mental health counseling, drug or alcohol treatment, HIV and AIDS screening and related information, including counseling notes.

**Disclosure Notice:** Federal and State laws specifically require that any disclosure or re-disclosure of mental health, drug/alcohol, HIV screening and AIDS related information must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any drug or alcohol abuse patient. (See also Iowa Code Chapter 228 and section 141A.9 and applicable laws.)

**If known, list all providers such as counselor, agency, hospital clinic, mental health provider, etc.**

<b>Provider</b>	<b>Address, City, State, Zip</b>	<b>Telephone</b>

- I specifically authorize any hospital, clinic, doctor, insurance company, agency or mental health provider, including the University of Iowa Hospitals and Clinics, to release information to the CVC Program of the Iowa Department of Justice. I specifically authorize disclosure and re-disclosure of this information as provided in section 3 of this form. This authorization is valid for information already in existence and any information generated while authorization is in effect. I understand that:
- The CVC Program will request only information needed to determine about CVC benefits for which I am eligible.
- This information release is valid for one year from the date of my signature and that I can cancel this release by writing to the CVC program at any time, except that if information has already been received and used it is not subject to cancellation.
- I have a right to inspect the disclosed mental health information at any time by contacting the mental health provider who has the records.
- A photocopy of this signed form is as valid as the original; and
- My signature gives permission for the release of all information specified in this permission form.

**X SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
*Applicant signature (Parent or guardian must sign if victim is a minor or dependent adult; applicant must signed if victim is deceased.)*